TIMBERLAWN MENTAL HEALTH SYSTEM[SM]

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

The individual Mandee Cloud, being served at Timberlawn Mental Health System[SM] (Facility), on: 9-16-07 (Date)

has received a complete explanation of: Adderall (Name of Medication)

The explanation was given to the individual in simple, nontechnical language and included:	Indicate Accomplishment by a check mark
1) The nature of his/her mental and physical condition.	✓
2) The expected beneficial effects on his/her condition as a result of treatment with the medication (s).	✓
3) The probable health and mental health consequences of not taking medication, including the occurrence, increase or reoccurrence of symptoms of mental illness.	✓
4) The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefit as the medication(s) and why the physician rejects the alternative treatment.	✓
5) A description of the proposed course of treatment with the medication(s).	✓
6) The fact that side effects of varying degrees of severity are a risk of all medications.	✓
7) The relevant side effects of the medication(s) being prescribed are explained, including: (A) any side effects which are known to frequently occur in most individuals; (B) any side effects to which the individual may be predisposed; and (C) the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large dosages and/or over long periods of time.	✓
8) The need to advise staff immediately if any of these side effects occur.	✓
9) An instruction that the individual may withdraw consent at any time without negative actions on the part of the staff.	✓
10) A review of Patient's Rights Under the Consent to treatment with Psychoactive Medication Rule (See MHRS 9-7)	✓
11) An offer to answer any questions concerning this treatment.	✓

I have received a complete explanation of the psychoactive medication(s) by means of:
(Circle ~~those appropriate~~)
oral explanation video presentation printed material other _____ (specify)

(Continued on Back)

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

I have received the written information on medications as requested and the printed material which summarizes specific information regarding the psychoactive medication(s) for which I have given my consent.

Based upon this explanation, I hereby consent to treatment with a specific psychoactive medication or medication group (class) as indicated on the front of this form. I understand that I may withdraw this consent at any time, however a probate court may decide that I lack the capacity to make the decisions whether or not to take the medication(s) and decide that I must continue taking the psychoactive medication prescribed by my physician.

Mandie Cloud 9-16-07

Patient Date

Representative Relationship to Patient Date

[signature] RN 9-16-07

Physician, P.A., R.Ph., RN or LVN Giving Explanation Position Date

[signature] 9/16/07

Signature of Treating Physician to confirm explanation given by P.A., R.Ph., RN or LVN Date
(required within two working days of P.A., R.Ph., RN or LVN giving explanation)

CONSENT TO TREATMENT INVOLVING A MINOR:

If this consent is for treatment of a minor under the Texas Family Code, the following information must be provided.

a) Name of one or both parents, if known: _____

b) Name of legally authorized representative of person, if appointed: _____

c) Date on which treatment is to begin: _____ CONSENT GIVEN BY PHONE DATE: _____ TIME: _____

WITHDRAWAL OF CONSENT FOR MEDICATION:

I formally withdraw my consent for _____
(Name of Psychoactive Medication or Medication Group)

Patient Signature Date Witness Date

TIMBERLAWN MENTAL HEALTH SYSTEM℠

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

The indiv CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007, being served at Timberlawn Mental Health System℠ (Facility), on: 9/12/07 (Date)
MEDICARE C/Y
has receiv DR. FONTAINE explanation of: F ID Serax
Name of Medication

The explanation was given to the individual in simple, nontechnical language and included:	Indicate Accomplishment by a check mark
1) The nature of his/her mental and physical condition.	✓
2) The expected beneficial effects on his/her condition as a result of treatment with the medication (s).	✓
3) The probable health and mental health consequences of not taking medication, including the occurrence, increase or reoccurrence of symptoms of mental illness.	✓
4) The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefit as the medication(s) and why the physician rejects the alternative treatment.	✓
5) A description of the proposed course of treatment with the medication(s).	✓
6) The fact that side effects of varying degrees of severity are a risk of all medications.	✓
7) The relevant side effects of the medication(s) being prescribed are explained, including:	✓
(A) any side effects which are known to frequently occur in most individuals;	✓
(B) any side effects to which the individual may be predisposed; and	✓
(C) the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large dosages and/or over long periods of time.	✓
8) The need to advise staff immediately if any of these side effects occur.	✓
9) An instruction that the individual may withdraw consent at any time without negative actions on the part of the staff.	✓
10) A review of Patient's Rights Under the Consent to treatment with Psychoactive Medication Rule (See MHRS 9-7)	✓
11) An offer to answer any questions concerning this treatment.	✓

I have received a complete explanation of the psychoactive medication(s) by means of:
(Circle those appropriate)
oral explanation video presentation printed material other _____ (specify)

(Continued on Back)

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

I have received the written information on medications as requested and the printed material which summarizes specific information regarding the psychoactive medication(s) for which I have given my consent.

Based upon this explanation, I hereby consent to treatment with a specific psychoactive medication or medication group (class) as indicated on the front of this form. I understand that I may withdraw this consent at any time, however a probate court may decide that I lack the capacity to make the decisions whether or not to take the medication(s) and decide that I must continue taking the psychoactive medication prescribed by my physician.

Mandee Cano — 9/12/07
Patient — Date

Representative — Relationship to Patient — Date

Physician, P.A., R.Ph., RN or LVN Giving Explanation — Position — 9/12/07 — Date

Signature of Treating Physician to confirm explanation given by P.A., R.Ph., RN or LVN — 9/12/07 — Date
(required within two working days of P.A., R.Ph., RN or LVN giving explanation)

CONSENT TO TREATMENT INVOLVING A MINOR:

If this consent is for treatment of a minor under the Texas Family Code, the following information must be provided.

a) Name of one or both parents, if known: _____

b) Name of legally authorized representative of person, if appointed: _____

c) Date on which treatment is to begin: _____ CONSENT GIVEN BY PHONE DATE: _____ TIME: _____

WITHDRAWAL OF CONSENT FOR MEDICATION:

I formally withdraw my consent for _____
(Name of Psychoactive Medication or Medication Group)

Patient Signature — Date — Witness — Date

TIMBERLAWN MENTAL HEALTH SYSTEM℠

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

CLOUD, MANDEE
The indi M# 000119639 12/04/1975 , being served at Timberlawn Mental Health System℠, on: 9/12/07
(Facility) (Date)
A# 01347260018 09/12/2007
MEDICARE C/Y
has rece DR. FONTAINE F ID Clonazepam
Name of Medication

The explanation was given to the individual in simple, nontechnical language and included:	Indicate Accomplishment by a check mark
1) The nature of his/her mental and physical condition.	✓
2) The expected beneficial effects on his/her condition as a result of treatment with the medication (s).	✓
3) The probable health and mental health consequences of not taking medication, including the occurrence, increase or reoccurrence of symptoms of mental illness.	✓
4) The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefit as the medication(s) and why the physician rejects the alternative treatment.	✓
5) A description of the proposed course of treatment with the medication(s).	✓
6) The fact that side effects of varying degrees of severity are a risk of all medications.	✓
7) The relevant side effects of the medication(s) being prescribed are explained, including:	✓
(A) any side effects which are known to frequently occur in most individuals;	✓
(B) any side effects to which the individual may be predisposed; and	✓
(C) the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large dosages and/or over long periods of time.	✓
8) The need to advise staff immediately if any of these side effects occur.	✓
9) An instruction that the individual may withdraw consent at any time without negative actions on the part of the staff.	✓
10) A review of Patient's Rights Under the Consent to treatment with Psychoactive Medication Rule (See MHRS 9-7)	✓
11) An offer to answer any questions concerning this treatment.	✓

I have received a complete explanation of the psychoactive medication(s) by means of:
(Circle those appropriate)
oral explanation video presentation printed material other _____
(specify)

(Continued on Back)

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

I have received the written information on medications as requested and the printed material which summarizes specific information regarding the psychoactive medication(s) for which I have given my consent.

Based upon this explanation, I hereby consent to treatment with a specific psychoactive medication or medication group (class) as indicated on the front of this form. I understand that I may withdraw this consent at any time, however a probate court may decide that I lack the capacity to make the decisions whether or not to take the medication(s) and decide that I must continue taking the psychoactive medication prescribed by my physician.

Mandee Cloud
Patient

Date

Representative

Relationship to Patient

Date

Physician, P.A., R.Ph., RN or LVN Giving Explanation

Position

9/12/07
Date

Signature of Treating Physician to confirm explanation given by P.A., R.Ph., RN or LVN
(required within two working days of P.A., R.Ph., RN or LVN giving explanation)

Carlson MD 9/12/07
Date

CONSENT TO TREATMENT INVOLVING A MINOR:

If this consent is for treatment of a minor under the Texas Family Code, the following information must be provided.

a) Name of one or both parents, if known: _____

b) Name of legally authorized representative of person, if appointed: _____

c) Date on which treatment is to begin: _____ CONSENT GIVEN BY PHONE DATE: _____ TIME: _____

WITHDRAWAL OF CONSENT FOR MEDICATION:

I formally withdraw my consent for _____
(Name of Psychoactive Medication or Medication Group)

Patient Signature Date

Witness Date

TIMBERLAWN MENTAL HEALTH SYSTEM[SM]

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE

The indi –, being served at Timberlawn Mental Health System[SM] (Facility), on: 9/12/07 (Date)

has received a complete explanation on: F IDI hexapro
Name of Medication

The explanation was given to the individual in simple, nontechnical language and included:	Indicate Accomplishment by a check mark
1) The nature of his/her mental and physical condition.	✓
2) The expected beneficial effects on his/her condition as a result of treatment with the medication (s).	✓
3) The probable health and mental health consequences of not taking medication, including the occurrence, increase or reoccurrence of symptoms of mental illness.	✓
4) The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefit as the medication(s) and why the physician rejects the alternative treatment.	✓
5) A description of the proposed course of treatment with the medication(s).	✓
6) The fact that side effects of varying degrees of severity are a risk of all medications.	✓
7) The relevant side effects of the medication(s) being prescribed are explained, including:	✓
(A) any side effects which are known to frequently occur in most individuals;	✓
(B) any side effects to which the individual may be predisposed; and	✓
(C) the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large dosages and/or over long periods of time.	✓
8) The need to advise staff immediately if any of these side effects occur.	✓
9) An instruction that the individual may withdraw consent at any time without negative actions on the part of the staff.	✓
10) A review of Patient's Rights Under the Consent to treatment with Psychoactive Medication Rule (See MHRS 9-7)	✓
11) An offer to answer any questions concerning this treatment.	✓

I have received a complete explanation of the psychoactive medication(s) by means of:
(Circle those appropriate)
oral explanation video presentation printed material other _____ (specify)

(Continued on Back)

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

I have received the written information on medications as requested and the printed material which summarizes specific information regarding the psychoactive medication(s) for which I have given my consent.

Based upon this explanation, I hereby consent to treatment with a specific psychoactive medication or medication group (class) as indicated on the front of this form. I understand that I may withdraw this consent at any time, however a probate court may decide that I lack the capacity to make the decisions whether or not to take the medication(s) and decide that I must continue taking the psychoactive medication prescribed by my physician.

Mandee Cloud — Patient — Date: 9/12/07

Representative — Relationship to Patient — Date

Physician, P.A., R.Ph., RN or LVN Giving Explanation — Position — Date: 9/12/07

Signature of Treating Physician to confirm explanation given by P.A., R.Ph., RN or LVN — Date: 9/12/07
(required within two working days of P.A., R.Ph., RN or LVN giving explanation)

CONSENT TO TREATMENT INVOLVING A MINOR:

If this consent is for treatment of a minor under the Texas Family Code, the following information must be provided.

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b) Name of legally authorized representative of person, if appointed: _____

c) Date on which treatment is to begin: _____ CONSENT GIVEN BY PHONE DATE: _____ TIME: _____

WITHDRAWAL OF CONSENT FOR MEDICATION:

I formally withdraw my consent for _____
(Name of Psychoactive Medication or Medication Group)

Patient Signature — Date — Witness — Date

TIMBERLAWN MENTAL HEALTH SYSTEM℠

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

The in CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007, being served at Timberlawn Mental Health System℠ (Facility), on: 9/12/07 (Date)
MEDICARE C/Y
DR. FONTAINE F ID

has received a complete explanation of: Benadryl
Name of Medication

The explanation was given to the individual in simple, nontechnical language and included:	Indicate Accomplishment by a check mark
1) The nature of his/her mental and physical condition.	✓
2) The expected beneficial effects on his/her condition as a result of treatment with the medication (s).	✓
3) The probable health and mental health consequences of not taking medication, including the occurrence, increase or reoccurrence of symptoms of mental illness.	✓
4) The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefit as the medication(s) and why the physician rejects the alternative treatment.	✓
5) A description of the proposed course of treatment with the medication(s).	✓
6) The fact that side effects of varying degrees of severity are a risk of all medications.	✓
7) The relevant side effects of the medication(s) being prescribed are explained, including:	✓
(A) any side effects which are known to frequently occur in most individuals;	✓
(B) any side effects to which the individual may be predisposed; and	✓
(C) the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large dosages and/or over long periods of time.	✓
8) The need to advise staff immediately if any of these side effects occur.	✓
9) An instruction that the individual may withdraw consent at any time without negative actions on the part of the staff.	✓
10) A review of Patient's Rights Under the Consent to treatment with Psychoactive Medication Rule (See MHRS 9-7)	✓
11) An offer to answer any questions concerning this treatment.	✓

I have received a complete explanation of the psychoactive medication(s) by means of:
(Circle those appropriate)
oral explanation video presentation printed material other _____ (specify)

(Continued on Back)

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

I have received the written information on medications as requested and the printed material which summarizes specific information regarding the psychoactive medication(s) for which I have given my consent.

Based upon this explanation, I hereby consent to treatment with a specific psychoactive medication or medication group (class) as indicated on the front of this form. I understand that I may withdraw this consent at any time, however a probate court may decide that I lack the capacity to make the decisions whether or not to take the medication(s) and decide that I must continue taking the psychoactive medication prescribed by my physician.

x Mandee Cloud 9/12/07

Patient Date

Representative Relationship to Patient Date

Physician, P.A., R.Ph., RN or LVN Giving Explanation Position 9/12/07 Date

Signature of Treating Physician to confirm explanation given by P.A., R.Ph., RN or LVN 9/12/07 Date
(required within two working days of P.A., R.Ph., RN or LVN giving explanation)

CONSENT TO TREATMENT INVOLVING A MINOR:

If this consent is for treatment of a minor under the Texas Family Code, the following information must be provided.

a) Name of one or both parents, if known: _____

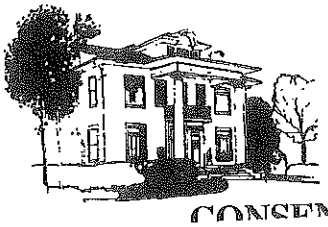
b) Name of legally authorized representative of person, if appointed: _____

c) Date on which treatment is to begin: _____ CONSENT GIVEN BY PHONE DATE: _____ TIME: _____

WITHDRAWAL OF CONSENT FOR MEDICATION:

I formally withdraw my consent for _____
(Name of Psychoactive Medication or Medication Group)

Patient Signature Date Witness Date



TIMBERLAWN MENTAL HEALTH SYSTEM[SM]

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

CLOUD, MANDEE
M# 000119639 12/04/1975
The indi A# 01347260018 09/12/2007, being served at Timberlawn Mental Health System[SM] (Facility), on: 9/12/07 (Date)
MEDICARE C/Y
DR. FONTAINE F ID
has received a complete explanation of: Trazadone
Name of Medication

The explanation was given to the individual in simple, nontechnical language and included:	Indicate Accomplishment by a check mark
1) The nature of his/her mental and physical condition.	✓
2) The expected beneficial effects on his/her condition as a result of treatment with the medication (s).	✓
3) The probable health and mental health consequences of not taking medication, including the occurrence, increase or reoccurrence of symptoms of mental illness.	✓
4) The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefit as the medication(s) and why the physician rejects the alternative treatment.	✓
5) A description of the proposed course of treatment with the medication(s).	✓
6) The fact that side effects of varying degrees of severity are a risk of all medications.	✓
7) The relevant side effects of the medication(s) being prescribed are explained, including: (A) any side effects which are known to frequently occur in most individuals; (B) any side effects to which the individual may be predisposed; and (C) the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large dosages and/or over long periods of time.	✓ ✓ ✓ ✓
8) The need to advise staff immediately if any of these side effects occur.	✓
9) An instruction that the individual may withdraw consent at any time without negative actions on the part of the staff.	✓
10) A review of Patient's Rights Under the Consent to treatment with Psychoactive Medication Rule (See MHRS 9-7)	✓
11) An offer to answer any questions concerning this treatment.	✓

I have received a complete explanation of the psychoactive medication(s) by means of:
(Circle those appropriate)
oral explanation video presentation printed material other _____ (specify)

(Continued on Back)

CONSENT TO TREATMENT WITH PSYCHOACTIVE MEDICATION

I have received the written information on medications as requested and the printed material which summarizes specific information regarding the psychoactive medication(s) for which I have given my consent.

Based upon this explanation, I hereby consent to treatment with a specific psychoactive medication or medication group (class) as indicated on the front of this form. I understand that I may withdraw this consent at any time, however a probate court may decide that I lack the capacity to make the decisions whether or not to take the medication(s) and decide that I must continue taking the psychoactive medication prescribed by my physician.

Marc Deadmond — 9/12/07
Patient — Date

Representative — Relationship to Patient — Date

Physician, P.A., R.Ph., RN or LVN Giving Explanation — Position — 9/12/07 Date

Signature of Treating Physician to confirm explanation given by P.A., R.Ph., RN or LVN — 9/12/07 Date
(required within two working days of P.A., R.Ph., RN or LVN giving explanation)

CONSENT TO TREATMENT INVOLVING A MINOR:

If this consent is for treatment of a minor under the Texas Family Code, the following information must be provided.

a) Name of one or both parents, if known: _____

b) Name of legally authorized representative of person, if appointed: _____

c) Date on which treatment is to begin: _____ CONSENT GIVEN BY PHONE DATE: _____ TIME: _____

WITHDRAWAL OF CONSENT FOR MEDICATION:

I formally withdraw my consent for _____
(Name of Psychoactive Medication or Medication Group)

Patient Signature — Date — Witness — Date

TIMBERLAWN MENTAL HEALTH SYSTEM℠

INTEGRATED ASSESSMENT

SECTION III PSYCHOSOCIAL EVALUATION

PERSONAL HISTORY

Informant: Mandee Cloud | If not patient: | Relationship:

Birthplace: Mesquite | Birth Order: Young | # of Siblings 1B 15

Age: 12.4.75 | Developmental Age (Child and Adolescent only):

As Evidenced by (Child and Adolescent only):

Mother: Nedra | Occupation

Age: 57

Is there Contact daily-person | History of ETOH/Drug Abuse ☐ | History of Mental Illness ☐

Deceased (Date)

Comments: (Specify if Relationship is Biological, Adoptive, Step, Etc) good rel.

Father: Nicky | Occupation died mo ago

Age:

Is there Contact | History of ETOH/Drug Abuse ☐ | History of Mental Illness ☐

Deceased (Date 2007)

Comments: (Specify if Relationship is Biological, Adoptive, Step, Etc) very close - grieving loss

FAMILY CHARACTERISTICS

Lower Socioeconomic ☐ | Alcoholic ☒ | Abusive ☐

Middle Class ☐ | Chaotic ☐ | Controlling ☐

Upper Class ☐ | Distant ☐ | Other

Open Communication ☐ | Family Involvement ☐

Comments: brother + sister dad: alcohol + drugs

Other Family Psychiatric History:

Family Strengths/ Weaknesses

CULTURAL ASSESSMENT

No Cultural Issues Identified ☒

Cultural Issues Identified (Specify)

MARITAL /FAMILY RELATIONSHIPS (Adults)

Single ____ | Significant Relationship ☐ | Heterosexual ☐

Married - # of Xs 1 | Conflictual Relationship ☐ | Homosexual ☐

Divorced - # of Xs ____ | Stable Relationship ☐ | Bisexual ☐

Other widowed since 2000

Comments: married 5 yrs

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE F ID

Number of Children (3) Biological ( ) Step ( ) Adopted

Are you a caretaker for anyone in or out of your home? Yes ☒ No ☐

Is anyone taking care of that individual? Yes ☒ No ☐ If so who? Mother

Comments: 15 y 12 y 10 y 3 yrs

SOCIAL DEVELOPMENT

Forms Friendships ☐ Supportive Friends ☐ Socially Isolated ☒

No Close Friends ☒

Maintains Friendships ☐ Needs ↑ Social Interaction ☒ Attends Social Functions ☐

Limited Support System ☐

Strengths: Weaknesses:

no support

Comments:

EDUCATIONAL HISTORY

Highest Grade Obtained: Elementary ____ Middle School 7th High School ____

Bachelors ☐ Masters ☐ PH.D. ☐ GED ☒ Voc.Tech ☐ Some College ☐

Good Student ☐ Learning Disabilities ☐ Extracurricular Activities ☐

Average Student ☐ Regular Classes ☐ Participation in Sports ☐

Poor Student ☐ Advanced Classes ☐

Special Ed ☐

School Behaviors (Children/ Adolescents)

Truancy ☐ Argumentative ☐ Fighting with Peers ☐

Poor Effort ☐ NA Disruptive ☐ Attentive ☐

Repeated Grades ☐ Expulsions ☐ Suspensions ☐

Use of Drugs/ETOH ☐ Difficulty with Peers ☐

Other ____

Comments:

EMPLOYMENT HISTORY (Adults)

Employed – Where:

Occupation: cashier 5-6 years

Part time ☐ Full-time ☐ Sck Leave ☐ Unemployed ☐ Disabled ☒

Good Work Hx ☐ Poor Work Hx ☐ Homemaker ☐ Never Employed ☐ Will Return to Work ☐

Comments: not planning to work

MILITARY HISTORY (Adults)

No Military Hx ☒ Raised in Military Family ☐ Spouse in Military ☐

Served in Military: Army ☐ Navy ☐ Air Force ☐ Marines ☐ Other:

Dates of Service:

Type of Discharge: Honorable ☐ Dishonorable ☐ Medical ☐ Service Related Disability ☐ AWOL ☐

History of Treatment at VA Hospital Yes ☐ No ☐

Comments:

SPIRITUAL ASSESSMENT

Spiritual Preference (Specify):

Attends Regularly ☐ Does not Attend Regularly ☒

Actively Involved ☐ Source of Support ☐ Source of Concern ☐

Comments:

FINANCIAL HISTORY mother handles

Adequate Finances ☐ Inadequate Finances ☐ $ Stress ☐ Receives SSD ☐ Social Security ☐

VA Benefits ☐ Dependent on Others ☐ Receives SSI/SSD ☒

Comments: barely – mo. helps $589

PRELIMINARY DISCHARGE AND AFTERCARE PLANS

Where, with Whom will the Patient Live: c mother + 3 children + nephew (23)

Aftercare Therapy Therapist/ Clinic: Adapt - Janice Shane

Medication Management Doctor / Clinic: "

Special Placement Issues: helpful

Do you have any guns in the home? Yes ☒ No ☐

Are they secured or removed? Yes ☐ No ☐ no ammunition for them

Who can be contacted to assist in removing or securing the gun(s)?

HIGH RISK D/C CRITERIA

None Identified ☒

Functional Impairments: ☐ Hearing / Visual / Speech ☐ Communication Barriers

Cognitive Impairments: ☐ Decreased Intellectual Functioning ☐ Organicity ☐ Head Injury

Medical: ☐ Diabetes ☐ Respiratory ☐ Severe Pain ☐ Other

Support: ☐ No or Few Resources ☐ CPS or APS Custody ☐ Multiple Placements ☐ Sexual Perpetration History

Abuse History: ☐ Physical ☐ Verbal / Emotional ☐ Sexual ☐ Substance ☐ Other

Mobility Concerns: ☐ Physical Therapy ☐ Occupational Therapy ☐ Assistive Devices ☐ ADLs ☐ Other

Other: ☐ Trouble Taking Meds ☐ Trouble-Preparing Meds. ☐ Trouble Paying for Meds
☐ Transportation Issues to Appts.

Social Services Interventions: afterCare sem
group therapy

Problems Identified:

Social Services Staff

Social Worker Signature

Date/Time 9/13/7

Date/Time

TIMBERLAWN MENTAL HEALTH SYSTEM℠
INTEGRATED ASSESSMENT

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE F ID

INTEGRATED ASSESSMENT
SECTION IV INTEGRATED SUMMARY

Patient is a 30 year old W (race), female (gender), admitted for:

Axis I: Major depression d/s
PTSD
cocaine depends

Axis II: def

Axis III: none

Axis IV: 1° support (severity) severe

Axis V: GAF admission: 25 GAF past year: 65

Presenting Problems: (Prior Treatment yes ☐ no ☒ unknown ☐ _____ x's)

depression
cocaine dep

Patient has responded to prior treatment by:

NA

Medical Problems include: (see nursing assessment for more detailed information)

good

Strengths:

ADLs

Weaknesses:

↓ 1° support

Issues to be addressed in treatment:

depression, + C.D.

Issues to be deferred to longer treatment:

none

Prognosis is Good Fair Poor

[signature]
Social Services Worker

9/13/
Date and Time

Form # 3421 C Sec. 2/06

ACTIVITY ASSESSMENT
ADULT SERVICES

FITNESS

1. Do you have any physical or other limitations that might interfere with participation in recreational activities?
   If yes, describe: no
2. Do you exercise on a regular basis?
   What type?
   Frequency? no

SOCIAL/LEISURE

3. What type of leisure activities have you done recently? watch TV, drink
4. Do you drive? yes
5. Do you have your own transportation? ~~yes~~ no
6. What do you do when bored or lonely? ~~yes~~ drink
7. Do you spend time with your family? Why or why not? yes obligation
8. What are your current hobbies? no
9. Does your work schedule interfere with your leisure activities? disability
10. Do you belong to any social groups or community organizations? no
11. Do your finances allow you to have leisure interest comfortably? no
12. Have you used (alcohol) or (drugs)? lepk - case daily crack, meth, MJ
    Does any of the following apply to your use?
    to block feelings ✓ to relax ____ to be more sociable ✓ to change your mood ✓
    Comments ____
13. Do you need to improve in the following areas?
    Time management ✓ Stress Management ✓ Relaxation techniques ✓
    Concentration on tasks ✓ Information about community leisure resources ✓
    Other ____

TREATMENT RECOMMENDATIONS

Activity treatment plan / objective: ↑ awareness of ↑ outlets through the use of leisure activities

New problems identified: none

Community referrals given: yes

Group involvement/ frequency: lepk

Assessed by: JBriggs CTRS Date: 9-15-07

TIMBERLAWN
MENTAL HEALTH SYSTEM
ACTIVITY ASSESSMENT
ADULT SERVICES

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE F IDL

ACTIVITY THERAPY DAILY DOCUMENTATION

Key to terms:
Column 1 - Session Date and Time
Column 2 - Interventions Offered
AT - Activity Therapy
CS - Cognitive Skills
IS - Interpersonal Skills
LS - Life Satisfaction
SE - Self Expression
SM - Symptom Management

Column 4 - Objective Progress
\+ - Increase in objective skill ability
– - Decrease in objective skill ability
0 - No Change
A - Objective achieved

Column 5 - Planned Interventions
A. Encourage increased participation
B. Encourage appropriate social skills
C. Encourage focus on treatment issues
D. Encourage self-expression/self awareness

Column 6 - Evaluation of Patient's Progress toward Goal

Column 3 - Objective
A. Increase knowledge of benefits of daily physical activity
B. Increase knowledge healthy leisure lifestyle
C. Increase self-esteem and self-confidence
D. Increase healthy expression of feelings
F. Increase symptom management skills
G. Increase stress management skills
H. Increase anger management skills
I. Increase relaxation skills
J. Increase recreation/leisure skills
K. Increase social and/or communication skills
L. Increase problem solving skills
M. Increase decision-making skills
N. Increase frustration tolerance
O. Increase concentration and attention span
P. Increase impulse control
Q. Increase reality-based input
R. Increase self-care/hygiene
S. Increase awareness for discharge planning
T. Other (specify) _____

Session Date /Time	Inter-ventions Offered	Objective	Objective Progress	Planned Inter-ventions	Problem #	Evaluation of Behavior
9-14 900	AT					refused x Buggy CRS Signature: _____
9-16 1530	AT	J,K	0	A,B	1	Pt had moderate participation assisting activity partner & activity, pt had a flat affect, although did smile at times. A. Chandler, TRA Signature: x Buggy CRS
9-17 300	AT	A	0	EA	1	Depressed no participation & min interaction & peers flat affect encouraged to do more Signature: x Buggy CRS
9-18 300	AT	A	0	A	1	Participated little depressed flat affect distant min interaction & peers Signature: x Buggy CRS

TIMBERLAWN MENTAL HEALTH SYSTEM℠
ACTIVITY THERAPY DAILY DOCUMENTATION

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ACTIVITY THERAPY DAILY DOCUMENTATION

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K. Increase social and/or communication skills
L. Increase problem solving skills
M. Increase decision-making skills
N. Increase frustration tolerance
O. Increase concentration and attention span
P. Increase impulse control
Q. Increase reality-based input
R. Increase self-care/hygiene
S. Increase awareness for discharge planning
T. Other (specify) _____

Session Date /Time	Inter-ventions Offered	Objective	Objective Progress	Planned Inter-ventions	Problem #	Evaluation of Behavior
9-19 300	AT	B	0	A	1	No input sat and stared flat affect depressed Signature: xBriggs CTRS
9-20 300	AT	B	0	C,D	1	Participated min by nodes now and then flat affect eyes half open depressed little feedback Signature: xBriggs CTRS
9-21 915	AT	A	0	C,D	1	Participated however depressed min feedback difficulty focusing on issues distant Signature: xBriggs CTRS
9-23 1545	AT	A,K	0	B,C	1	Pt. had moderate participation, walking & peers, some verbal interactions, flat affect. A. Thornday TRT Signature: xBriggs CTRS

TIMBERLAWN
MENTAL HEALTH SYSTEM
ACTIVITY THERAPY DAILY DOCUMENTATION

ACTIVITY THERAPY DAILY DOCUMENTATION

Key to terms:

Column 1 - Session Date and Time

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M. Increase decision-making skills
N. Increase frustration tolerance
O. Increase concentration and attention span
P. Increase impulse control
Q. Increase reality-based input
R. Increase self-care/hygiene
S. Increase awareness for discharge planning
T. Other (specify) _____

Column 4 - Objective Progress

\+ - Increase in objective skill ability
– - Decrease in objective skill ability
0 - No Change
A - Objective achieved

Column 5 - Planned Interventions

A. Encourage increased participation
B. Encourage appropriate social skills
C. Encourage focus on treatment issues
D. Encourage self-expression/self awareness

Column 6 - Evaluation of Patient's Progress toward Goal

Session Date /Time	Inter-ventions Offered	Objective	Objective Progress	Planned Inter-ventions	Problem #	Evaluation of Behavior
9-24 700	AT	B	0	A	1	Quiet and unmotivated sat quietly & flat affect no input depressed Signature: KBriggs CTRS
						Signature: _____
						Signature: _____
						Signature: _____

TIMBERLAWN
MENTAL HEALTH SYSTEM SM
ACTIVITY THERAPY DAILY DOCUMENTATION

ACTIVITY THERAPY DAILY DOCUMENTATION

Key to terms:
Column 1 - Session Date and Time
Column 2 - Interventions Offered
AT - Activity Therapy
CS - Cognitive Skills
IS - Interpersonal Skills
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S. Increase awareness for discharge planning
T. Other (specify) _____

Session Date /Time	Inter-ventions Offered	Objective	Objective Progress	Planned Inter-ventions	Problem #	Evaluation of Behavior
						Signature: _____
						Signature: _____
						Signature: _____
						Signature: _____

TIMBERLAWN
MENTAL HEALTH SYSTEM℠
ACTIVITY THERAPY DAILY DOCUMENTATION

SUBSTANCE	AGE OF	HOW USED	INTENSITY	DURATION	LAST USE
Alcohol	4-5	4 bottles/week (32 oz)		10 years	9/10
Amphetamines	denies				
Caffeine		12 pks pop/day			
Cocaine		crack 3-4 days/wk		for 4 years	9/11
GHB	denies				
Hallucinogens					
Inhalants	✓				
Marijuana		2X week for past month			
Methamphetamine	12	had a bad binge past ICE - weekly for		2 months	9/7
Nicotine		1 PK/day			
Opiates	denies				
Prescriptions		hydrocodon			2 mo.
Other	denies				

2. Substance of choice: alcohol + cocaine
3. What substances are currently in your home or possession?: none
4. Have they been removed or secured? ☐ Yes ☒ ~~No~~ Is there anyone we can contact to help you secure or remove them?
5. Are others currently using in your home?: none
6. Previous treatment and responses to that treatment: none

TIMBERLAWN MENTAL HEALTH SYSTEM
SUBSTANCE ABUSE ASSESSMENT

CLOUD, MANDEE
M# 000119639 12/04/1975
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MEDICARE C/Y
DR. FONTAINE
F ID

7. Have you ever:

A. Used more substances than you intended?	(Y)	N	L. Had legal problems due to using?	Y	(N)
B. Planned your day around substances?	(Y)	N	M. Used alone?	(Y)	N
C. Used continuously for several days?	(Y)	N	N. Became physically or verbally abusive while using?	(Y)	N
D. Had change in sexual activity?	Y	(N)	O. Used different pharmacies or physicians?	Y	(N)
E. Tried to stop using?	(Y)	N	P. Had a change in tolerance?	Y	(N)
F. Had shakes, tremors, sweats, or convulsions?	Y	(N)	Q. Had a change in social life / friends?	Y	(N)
G. Had memory loss / blackouts?	(Y)	N	R. Had a change in physical appearance?	Y	(N)
H. Neglected or had problems with family?	(Y)	N	S. Experienced increases / decreases in how much you use?	Y	(N)
I. Had work or school problems?	(Y)	N	T. Had advise from a physician to restrict use?	Y	(N)
J. Had financial problems?	(Y)	N			
K. Had emotional problems because of using?	(Y)	N			

8. Medical consequences of use: don't know

9. Educational consequences of use: no

10. Vocational consequences of use: yes

11. Financial consequences of use: yes

12. Legal consequences of use: no

13. Spiritual consequences of use: yes

14. Relationship consequences: yes: ma, children

15. Other consequences: no

16. Describe motivation for change: cuddy's me to live

17. Describe obstacles to recovery, including substance use by family: don't know

18. Recommendations for treatment: I.O.P. - (Check out Adept)

Signature B Hall

Date 9/13/7

TIMBERLAWN
MENTAL HEALTH SYSTEM℠
SUBSTANCE ABUSE ASSESSMENT

DISCHARGE PLANNING LOG

Date and Time	Service Code	Comments
9-13-07	SW	Met w/ pt. started a discussion
9AM		on d/c plans, pt. states she
		is a client w/ A-dapt, says
		her Doctor is Dr. Bennett,
		Nurse Practitioner is Janice Lam.
		sw to f/u. Johnnie Eppenn CMSW
9-19-07	SW	Meeting w/ pt. d/c dimussion,
9AM		pt. states she thinks she'll be
		ready to leave next week, pt
		will discuss w/ her doctor.
		Pt. states her f/u appt. is
		Nov. 1 @ 9:30 AM w/ A-dapt
		Dr. Bennett. Pt. also wants
		to Attend TMHS IOP.
		Johnnie Eppenn CMSW
9.21.07	SW	SW met w/ pt Re: scheduling
10:30am		FT w/ 2 daughters. Pt will set
		apt. and notify sw. S. Martin, LPC

TIMBERLAWN
MENTAL HEALTH SYSTEM℠
DISCHARGE PLANNING LOG

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE F ID

DISCHARGE PLANNING LOG

Date and Time	Service Code	Comments
9/21/07	SW	Pt's mother cannot do FT until after SW hours. Will do a phone FT or come in early Thursday 9/27. Pt's CM will let us know which over weekend. J. Epperson MSW
9/21/07 3:30 pm	SW	Pt. states she has a prior appt. already scheduled for 11/1/07 @ 9:30 AM w/ A dept. Pt. will re-schedule only if needed. J. Epperson LMSW
9/24/07 8:45 AM	SW	FT w/ pt's Mom on tel. @ families request. Please see note in chart in social services section. Johnnie Epperson LMSW

TIMBERLAWN MENTAL HEALTH SYSTEM℠
DISCHARGE PLANNING LOG

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE F IDI

NUTRITIONAL RISK ASSESSMENT

Pt NAME Cloud, Mandee HEIGHT 5'4" WEIGHT 157.0 lbs

NOTES: Not eating x 4 days 0 sleeping

Does the patient report the following conditions :

ANOREXIA / BULIMIA NERVOSA	(NO) YES = 10
RENAL DISEASE	(NO) YES = 10
CROHN'S DISEASE and / or COLITIS	(NO) YES = 10
GASTRIC BYPASS / BARIATRIC BANDING	(NO) YES = 10
MALABSORPTION and / or DECUBITUS	(NO) YES = 10
DIABETES	(NO) YES = 10
CANCER WITH WASTING SYNDROME	(NO) YES = 10
HIV / AIDS WITH WASTING SYNDROME	(NO) YES = 10

Is patient currently taking the following medications : (circle all that apply)

MAO INHIBITORS / LITHIUM / ORAL ANTIBIOTICS List name of medication None (NO) YES = 10

Do available labs DEVIATE from normal limits for : (circle all that apply)

GLUCOSE / HGB / HCT / CHOL / TRIG (NO) YES = 10

Does the patient report the following conditions :

NAUSEA / VOMITING PERSISTING FOR THE PAST 3 DAYS	(NO) YES = 5
CARDIOVASCULAR DISEASE	(NO) YES = 5
LIVER DISEASE	(NO) YES = 5
GAIN / (LOSS) of 10% (or higher) body mass WITHOUT TRYING in last 6 mos. 20lbs/2mos	NO (YES) = 5
PREGNANT OR LACTATING	(NO) YES = 5
TROUBLE CHEWING and / or SWALLOWING	(NO) YES = 5 - Order Mech Soft Diet

5

Does patient report FOOD ALLERGIES? (NO) YES = 0 - Order Appropriate Diet

List: None

Does the patient report FOOD RESTRICTIONS? (religious/cultural) (NO) YES = 0 - Order Appropriate Diet

List: None

Add Risk Points

5 Total Risk Points

Order a Dietary Consult if :NRA TOTAL Risk Points = 10 (or more)

To order a DIETARY CONSULT : FAX the WHITE COPY of the NRA to x6402

FOR ALL ASSESSMENTS : Place White NRA copy in Pt chart : Blue NRA copy in Unit's RD box

Signature [signature] Date 9/6/07 Time 1830

TIMBERLAWN MENTAL HEALTH SYSTEM℠

Patient identification

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y

ALCOHOL WITHDRAWAL FLOWSHEET

Detox Q2° ☑
Q4° ☐

— Draw a vertical line through non-applicable areas —

Date	9/12/07 2100	09/12/07								
Time	2100	2300								
Temperature	97°	97.6								
Pulse	73	102								
Respiration	16	16								
Blood Pressure	109/84	86/66								
Refer to Alcohol Withdrawal Assessment Scale to obtain scores for sections below										
Agitation	2									
Diaphoresis										
Fever										
Hallucinations										
Level of Consciousness										
Nausea & Vomiting										
Seizures										
Sleeplessness										
Staff Assessment of Level of Craving										
Tachycardia		1								
Tremor (arm extending and fingers spread)	2									
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)										
TOTAL SCORE	4	1								
Medication Dose Given	Seroquel 300mg									
Result & Time										
RN Name										

SIGNATURES	INT	SIGNATURES	INT
Eastman, K			

TIMBERLAWN
MENTAL HEALTH SYSTEM℠
ALCOHOL WITHDRAWAL FLOWSHEET

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE F ID

ALCOHOL WITHDRAWAL ASSESSMENT SCALE

Symptom	Points	Scale Criteria
Agitation	1 2	fidgety; irritable pacing; thrashing in bed
Diaphoresis	1 2 3	mild, barely visible moderate marked; clothes or bedding soaked
Fever	1 2	temperature 99-100.9 degrees F or 38-38.9 degrees C temperature > 101 degrees F or > 39 degrees C
Hallucinations	12*	tactile, auditory or visual hallucination *NOTIFY PHYSICIAN IMMEDIATELY
Level of Consciousness	1 3 12*	detached; altered sensorium; easily distracted disorientation at intervals of moderate duration marked disorientation; delirium tremens *NOTIFY PHYSICIAN IMMEDIATELY
Nausea / Vomiting	1 2 3	nausea only vomits once or twice within 8 hours frequent dry heaves or more than two vomiting episodes within 8 hours
Seizures	1	*NOTIFY PHYSICIAN IMMEDIATELY
Sleeplessness	1 2	awake two or three times during the night less than four hours sleep at night with no daytime naps
Staff Assessment of Level of Craving	2 4 6	mild moderate severe
Tachycardia	1 2 4	pulse rate 100-109 pulse rate 110-129 pulse rate > 130
Tremor (assess with arm extended and fingers spread)	1 2 3	minor tremor felt by examiner but not visible moderate, visible tremor marked, visible tremor
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)	4 6	SBP 151-175 mm Hg or DBP 100-109 mm Hg SBP > 175 mm Hg or DBP > 110 mm Hg

ALCOHOL WITHDRAWAL FLOWSHEET

Detox Q2° ☑ Q4° ☐

— Draw a vertical line through non-applicable areas —

Date 9-13-07					09/12/07	09/13	09/13	09/13		
Time	8:00	10:00	12:00	14:00	1800	1800	2000	2300		
Temperature	98.6	98.7	98.5	98.1	98.5	98.1	99.1	98.2		
Pulse	94	87	80	75	85	84	96	95		
Respiration	18	18	18	18	18	18	18	18		
Blood Pressure	128/91	109/73	115/78	112/77	103/57	112/84	116/99	112/79		
Refer to Alcohol Withdrawal Assessment Scale to obtain scores for sections below										
Agitation	0	0	0	0						
Diaphoresis	0	0	0	0						
Fever	0	0	0	0						
Hallucinations	0	0	0	0						
Level of Consciousness	0	0	0	0						
Nausea & Vomiting	0	0	0	0						
Seizures	0	0	0	0						
Sleeplessness	0	0	0	0						
Staff Assessment of Level of Craving	0	0	0	0						
Tachycardia	0	0	0	0						
Tremor (arm extending and fingers spread)	0	0	0	0						
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)	0	0	0	0						
TOTAL SCORE	0	0	0	0	0	0	0	0		
Medication Dose Given	0	0	0	0	1	1	1	1		
Result & Time	0	0	0	0	0	0	0	0		
RN Name	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		

SIGNATURES	INT	SIGNATURES	INP
[illegible]	[illegible]	Kellison, RN	[illegible]

TIMBERLAWN MENTAL HEALTH SYSTEM℠

ALCOHOL WITHDRAWAL FLOWSHEET

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE

F ID

207 A

ALCOHOL WITHDRAWAL ASSESSMENT SCALE

Symptom	Points	Scale Criteria
Agitation	1 2	fidgety; irritable pacing; thrashing in bed
Diaphoresis	1 2 3	mild, barely visible moderate marked; clothes or bedding soaked
Fever	1 2	temperature 99-100.9 degrees F or 38-38.9 degrees C temperature > 101 degrees F or > 39 degrees C
Hallucinations	12*	tactile, auditory or visual hallucination *NOTIFY PHYSICIAN IMMEDIATELY
Level of Consciousness	1 3 12*	detached; altered sensorium; easily distracted disorientation at intervals of moderate duration marked disorientation; delirium tremens *NOTIFY PHYSICIAN IMMEDIATELY
Nausea / Vomiting	1 2 3	nausea only vomits once or twice within 8 hours frequent dry heaves or more than two vomiting episodes within 8 hours
Seizures	1	*NOTIFY PHYSICIAN IMMEDIATELY
Sleeplessness	1 2	awake two or three times during the night less than four hours sleep at night with no daytime naps
Staff Assessment of Level of Craving	2 4 6	mild moderate severe
Tachycardia	1 2 4	pulse rate 100-109 pulse rate 110-129 pulse rate > 130
Tremor (assess with arm extended and fingers spread)	1 2 3	minor tremor felt by examiner but not visible moderate, visible tremor marked, visible tremor
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)	4 6	SBP 151-175 mm Hg or DBP 100-109 mm Hg SBP > 175 mm Hg or DBP > 110 mm Hg

ALCOHOL WITHDRAWAL FLOWSHEET

Detox Q2° ☒
Q4° ☐

— Draw a vertical line through non-applicable areas —

Date 9-14-07					09/14/07	09/14	09/14	09/14		
Time	8:00	10:00	12:00	14:00	1800	1800	2000	2300		
Temperature	98.2	98.4	97.5	98.1	99.0	98.6	98.5	98.4		
Pulse	84	82	73	71	76	91	84	80		
Respiration	18	18	18	18	18	18	18	18		
Blood Pressure	120/82	118/84	134/89	108/68	122/87	128/83	125/83	124/85		
Refer to Alcohol Withdrawal Assessment Scale to obtain scores for sections below										
Agitation	0	0	0	0	0	0				
Diaphoresis	0	0	0	0	0	0				
Fever	0	0	0	0	0	0				
Hallucinations	0	0	0	0	0	0				
Level of Consciousness	0	0	0	0	0	0				
Nausea & Vomiting	0	0	0	0	0	0				
Seizures	0	0	0	0	0	0				
Sleeplessness	0	0	0	0	0	0				
Staff Assessment of Level of Craving	0	0	0	0	0	0				
Tachycardia	0	0	0	0	0	0				
Tremor (arm extending and fingers spread)	0	0	0	0	0	0				
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)	0	0	0	0	0	0				
TOTAL SCORE	0	0	0	0	0	0	0	0		
Medication Dose Given	NA	NA	NA	NA	/	/	/	/		
Result & Time	NA	NA	NA	NA	/	1600	1600	1600		
RN Name	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		

SIGNATURES	INT	SIGNATURES	INT
[illegible]	[illegible]	[illegible]	[illegible]

TIMBERLAWN
MENTAL HEALTH SYSTEM℠
ALCOHOL WITHDRAWAL FLOWSHEET

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE

F ID

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Tremor (assess with arm extended and fingers spread)	1 2 3	minor tremor felt by examiner but not visible moderate, visible tremor marked, visible tremor
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)	4 6	SBP 151-175 mm Hg or DBP 100-109 mm Hg SBP > 175 mm Hg or DBP > 110 mm Hg

ALCOHOL WITHDRAWAL FLOWSHEET

Detox Q2° ☒
Q4° ☐

— Draw a vertical line through non-applicable areas —

Date 9.15.09										
Time	0900	1100	1300	1500	1700	1900	2100			
Temperature	97.6	98.4	98.0	98.4	97.6	98.3	98.6			
Pulse	84	75	74	80	76	86	85			
Respiration	16	16	16	16	16	16	16			
Blood Pressure	126/87	119/84	122/83	124/88	127/87	137/86	139/88			
Refer to Alcohol Withdrawal Assessment Scale to obtain scores for sections below										
Agitation							0			
Diaphoresis										
Fever										
Hallucinations										
Level of Consciousness										
Nausea & Vomiting										
Seizures										
Sleeplessness										
Staff Assessment of Level of Craving										
Tachycardia										
Tremor (arm extending and fingers spread)										
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)										
TOTAL SCORE	0	0	0	0	0	0	0			
Medication Dose Given	0	0	0	K	—	—	—			
Result & Time					—	—	—			
RN Name	TR	JR	JR	JR	DW	DW	DW			

SIGNATURES	INT	SIGNATURES	INT
		TR — R. Rodes RD	JR

TIMBERLAWN
MENTAL HEALTH SYSTEM℠
ALCOHOL WITHDRAWAL FLOWSHEET

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE

ALCOHOL WITHDRAWAL ASSESSMENT SCALE

Symptom	Points	Scale Criteria
Agitation	1 2	fidgety; irritable pacing; thrashing in bed
Diaphoresis	1 2 3	mild, barely visible moderate marked; clothes or bedding soaked
Fever	1 2	temperature 99-100.9 degrees F or 38-38.9 degrees C temperature > 101 degrees F or > 39 degrees C
Hallucinations	12*	tactile, auditory or visual hallucination *NOTIFY PHYSICIAN IMMEDIATELY
Level of Consciousness	1 3 12*	detached; altered sensorium; easily distracted disorientation at intervals of moderate duration marked disorientation; delirium tremens *NOTIFY PHYSICIAN IMMEDIATELY
Nausea / Vomiting	1 2 3	nausea only vomits once or twice within 8 hours frequent dry heaves or more than two vomiting episodes within 8 hours
Seizures	1	*NOTIFY PHYSICIAN IMMEDIATELY
Sleeplessness	1 2	awake two or three times during the night less than four hours sleep at night with no daytime naps
Staff Assessment of Level of Craving	2 4 6	mild moderate severe
Tachycardia	1 2 4	pulse rate 100-109 pulse rate 110-129 pulse rate > 130
Tremor (assess with arm extended and fingers spread)	1 2 3	minor tremor felt by examiner but not visible moderate, visible tremor marked, visible tremor
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)	4 6	SBP 151-175 mm Hg or DBP 100-109 mm Hg SBP > 175 mm Hg or DBP > 110 mm Hg

ALCOHOL WITHDRAWAL FLOWSHEET

Detox Q2° ☒
Q4° ☐

— Draw a vertical line through non-applicable areas —

Date 9-11-09										
Time	0900	1100	1300	1500	1700	1900	2100			
Temperature	98.2	98.8	98.4	98.9	96.0	99.2	98.2			
Pulse	94	93	98	90	87	93	93			
Respiration	16	16	16	16	16	16	16			
Blood Pressure	124/84	125/82	129/82	155/84	130/85	145/91	131/81			
Refer to Alcohol Withdrawal Assessment Scale to obtain scores for sections below										
Agitation						0	0			
Diaphoresis										
Fever										
Hallucinations										
Level of Consciousness										
Nausea & Vomiting										
Seizures										
Sleeplessness										
Staff Assessment of Level of Craving										
Tachycardia										
Tremor (arm extending and fingers spread)										
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)										
TOTAL SCORE	0	0	0	0	0	1	0			
Medication Dose Given						—	—			
Result & Time						—	—			
RN Name	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]			

SIGNATURES	INT	SIGNATURES	INT
[illegible]			
[illegible]	[illegible]		

TIMBERLAWN
MENTAL HEALTH SYSTEM℠
ALCOHOL WITHDRAWAL FLOWSHEET

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE

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ALCOHOL WITHDRAWAL FLOWSHEET

— Draw a vertical line through non-applicable areas —

Detox Q2° ☑ Q4° ☐

Date 9-17-07			09/17/07	09/17						
Time	8:00	(2:00)	1600	2000	2400					
Temperature	97.5	98.3	98.5	99.1						
Pulse	89	89	106	96						
Respiration	18	18	18	18						
Blood Pressure	129/89	131/83	114/78	135/90						
Refer to Alcohol Withdrawal Assessment Scale to obtain scores for sections below										
Agitation										
Diaphoresis										
Fever				1						
Hallucinations										
Level of Consciousness										
Nausea & Vomiting										
Seizures										
Sleeplessness										
Staff Assessment of Level of Craving										
Tachycardia			1							
Tremor (arm extending and fingers spread)										
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)										
TOTAL SCORE	0	0	1	1						
Medication Dose Given			1	1						
Result & Time			1600	2000						
RN Name	CM	CM	LD	LD						

SIGNATURES	INT	SIGNATURES	INT
Madley RN	CM	Fontaine, LD	LD

TIMBERLAWN MENTAL HEALTH SYSTEM℠
ALCOHOL WITHDRAWAL FLOWSHEET

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE F ID

ALCOHOL WITHDRAWAL ASSESSMENT SCALE

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ALCOHOL WITHDRAWAL FLOWSHEET

Detox Q2° ☐
Q4° ☒

— Draw a vertical line through non-applicable areas —

Date 9-18-07										
Time	8:00									
Temperature	98.4									
Pulse	112									
Respiration	20									
Blood Pressure	126/84									
Refer to Alcohol Withdrawal Assessment Scale to obtain scores for sections below										
Agitation										
Diaphoresis										
Fever										
Hallucinations										
Level of Consciousness										
Nausea & Vomiting										
Seizures										
Sleeplessness										
Staff Assessment of Level of Craving										
Tachycardia	A									
Tremor (arm extending and fingers spread)										
Hypertension (only count numbers in the absence of HTN diagnosis or Hx)										
TOTAL SCORE	2									
Medication Dose Given										
Result & Time										
RN Name	CH									

SIGNATURES	INT.	SIGNATURES	INT
Mcadlen RN	CH		

TIMBERLAWN MENTAL HEALTH SYSTEM℠
ALCOHOL WITHDRAWAL FLOWSHEET

CLOUD, MANDEE
M# 000119639 12/04/1975
A# 01347260018 09/12/2007
MEDICARE C/Y
DR. FONTAINE

F ID 207 A

ALCOHOL WITHDRAWAL ASSESSMENT SCALE

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Form # 3041 2/05

1205

TIMBERLAWN MENTAL HEALTH SYSTEM℠

INTEGRATED ASSESSMENT

SECTION II NURSING ASSESSMENT

VITAL SIGNS:	T	P	R	B/P
	98.3	81	18	118/77

Height 5'4 Weight 157

MEDICAL HISTORY

ALLERGIES: ☒ NKA
Medications: None

Foods: None

NURSING PHYSICAL ASSESSMENT

(check ALL that apply and note abnormalities in "comments")

VISION:
☒ No Problems ☐ Glasses ☐ Contact Lens ☐ Blurred
☐ Farsighted ☐ Nearsighted ☐ Astigmatism ☐ Cataracts

Comments:

NEUROLOGICAL:
☒ No Problems ☐ Numbness ☐ Loss of Consciousness
☐ Migraine Headache ☐ Tingling ☐ Fainting
☐ Vertigo ☐ Motor Weakness ☐ Seizures

Comments:

SEXUAL ASSESSMENT:
Last Menses 6/07/07 ☐ Post-Menopausal ☐ Menorrhagia ☐ Hx of STD
☐ Amenorrhea ☐ Genital Discharge
Last Pap Smear: 6/7/07 ☐ Birth Control ☐ Decreased Libido
☐ Not Sexually Active ☐ Pregnant: ☐ Impotence
☒ Sexually Active # of Months _____ ☐ Prostate Problems

Comments: Hysterectomy 6/07/07

EAR/NOSE/THROAT:
☒ No Problems ☐ Tinnitus ☐ Cold Symptoms
☐ Dental Problems ☐ Hearing Loss (R/L) ☐ Sore Throats
☐ Rhinorrhea ☐ Dizziness ☐ Hoarseness

Comments:

CARDIOVASCULAR:
☒ No Problems ☐ Fatigue ☐ Edema ☐ Chest Pain
☐ Diaphoresis ☐ Pacemaker ☐ Hx of Cardiac Disease ☐ Hx H.T.N.

Comments:

TIMBERLAWN MENTAL HEALTH SYSTEM℠
INTEGRATED ASSESSMENT

CLOUD, MANDEE
M# 000119639 12/04/1975
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MEDICARE C/Y
DR. FONTAINE F IDI

NURSING PHYSICAL ASSESSMENT – Continued

(check ALL that apply and note abnormalities in "comments")

RESPIRATORY:
- [X] No Problems
- [ ] Cough (sputum)
- [ ] Tracheostomy
- [ ] S.O.B.
- [ ] Cough (blood)
- [ ] Asthma
- [ ] T.B.

Comments:

GENITOURINARY:
- [X] No Problems
- [ ] Frequency
- [ ] Hematuria
- [ ] Indwelling Cath.
- [ ] Urinary Incontinence
- [ ] Bladder/Urination Problems
- [ ] Hx Bladder Infections
- [ ] Pain on Urination

Comments:

GASTROINTESTINAL:
- [X] No Problems
- [ ] Constipation
- [ ] Heartburn
- [ ] Gastritis
- [ ] Anemia
- [ ] Aches/Soreness
- [ ] Nausea/Vomiting
- [ ] Ulcers
- [ ] Liver Disease
- [ ] Bowel Incontinence
- [ ] Bloody/Tarry Stools
- [ ] Diarrhea
- [ ] G.I. Bleeding
- [ ] Hepatitis
- [ ] Hemorrhoids

Comments:

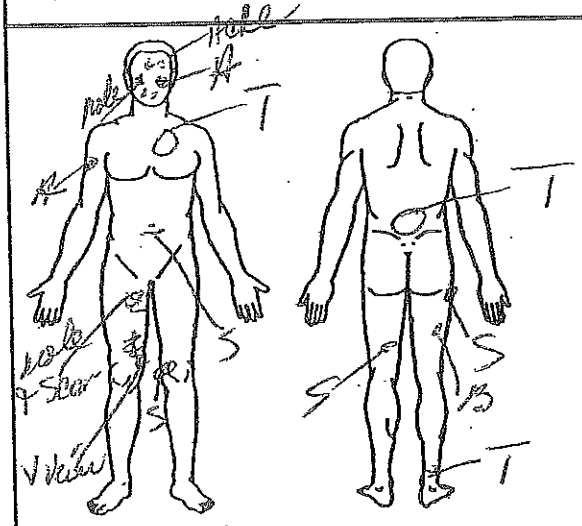
MUSCULOSKETAL:
- [X] No Problems
- [ ] Back Problems
- [ ] Prosthesis
- [ ] Amputations
- [ ] Muscle Weakness
- [ ] Bone & Joint Problems
- [ ] Decreased ROM
- [ ] Paralysis
- [ ] Arthritis
- [ ] Fractures
- [ ] Cramping

Comments:

ENDOCRINE:
- [X] No Problems
- [ ] Diabetes
- [ ] Thyroid Problems

Comments:

SKIN ASSESSMENT



Using the scale on the right, place the appropriate letter on the body.

INDICATE:

B = Bruises
R = Rashes
W = Wounds
S = Scars
D = Decubitus
U = Ulcers
T = Tattoos
P = Body Piercing
L = Laceration
A = Abrasion

Color:
- [ ] Pale
- [ ] Jaundiced
- [ ] Flushed
- [X] Normal

Turgor:
- [ ] Poor
- [X] Adequate

Add to Master Problem List:

Indicate any marks identified on diagram. Include scars, bruises, abrasions, lacerations, decubitus, etc.

Add pertinent patient explanation or comments:

Tubal ligation scar - 1991

Staff completing skin assessment: *(one must be an RN/LVN)*

1. [illegible] 2. [illegible] Date 9/12/07